Tennessee
Health Equity Commission

Health Disparities Report
2008

Tennessee General Assembly
Health Equity Commission
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I. Introduction

The Health Equity Commission is administered through the Tennessee General Assembly (Section 3-15-401, Tennessee Code Annotated). The Commission was established in 1990 under the name "The Black Health Care Commission". In 2008, the name was changed to the Health Equity Commission to encompass all minorities and underserved citizens of Tennessee. The Commission is comprised of six members of the Legislature, three Senators and three Representatives and six health equity stakeholders from across the state.

The Commission works in collaboration with the Tennessee Department of Health – Division of Minority Health to explore and create policy and programs upstream to change outcomes downstream that affect the health and well-being of populations of color and underserved communities. Continued growth in the State's minority population, shorter life spans, poorer health status, higher rates of infant mortality, higher incidence of diabetes, heart disease, cancer, and HIV/Aids in these populations and gaps in access to care, emphasize the importance of sustaining the Commission's efforts.

Mission:

Collaborate with State Departments, health equity stakeholders and community members, to ensure that health priorities and health concerns of Tennessee's minority and underserved populations are adequately addressed. Examine current initiatives to ensure we are utilizing best practices and disseminate information focused on improving minority health and eliminating health disparities.

We accomplish our mission by helping to develop effective health policies and culturally competent programs, educating citizens on the social determinants of health, participating in State action meetings to share strategies and solutions, improve coordination and utilization of research and outcome evaluations, and promotion of cultural competency in health care delivery.

Vision:

Improve the health status of Tennessee's minority and underserved populations so they can lead healthier, more productive lives.

How does the work of the Commission benefit all Tennesseans?

Health is a powerful determinant of self-sufficiency, a goal that unites all communities. If we neglect basic prevention measures today, we guarantee ourselves even greater health care cost tomorrow. Improved health and prevention of serious health problems is good for the state's economy. Healthy families and a healthy workforce elevate the fortunes of the entire state.

II. Health Definitions:

Several terms are required to understand the concept of health equity.

- **Health disparities** are the differences in the incidence, prevalence, morbidity, mortality, burden of disease, access to prevention, screening & treatment services and other health indicators that exist between specific, different populations. These disparities are further influenced by socio-economic status and biases, including race, religion, sexual identity and immigrant status.

- **Health Equity** is the desired goal or outcome of efforts to eliminate health disparities; health equity also may be thought of as a process whose goal is the elimination of health disparities. The concept of health equity is based on valuing all persons equally and viewing health as essential to the well-being of society. Considering equity as a process, an equitable situation is one in which disparities are narrowing; considering equity as an outcome, it would be the absence of disparities. Achieving health equity allows everyone to realize hopes, satisfy needs, change or cope with life experiences, and participate fully in society.

- **Health** itself must be distinguished from *health care*. While health care can prolong survival and improve prognosis after some serious diseases. Health is defined as a "state of complete physical, mental and social well-being". Health is a state where people are performing at their best in both mind and body. Health is influenced by social determinants (defined on next page). The smaller the inequality gap, the better the health status of the overall population.

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III. THE SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across a state's population effectively determines length and quality of life. SDOH have a direct impact on the health of individuals and are the best predictors of the health status of the overall population.

Health is a multidimensional entity. Likewise, there are multiple factors that either maintain or disrupt its balance:

Social and Economic Environment: This means that individual and community socioeconomic factors; social norms, social support and community connectedness; employment and working conditions; living conditions; and culture, religion, and ethnicity shape health.

Physical Environment: The safety, quality and sustainability of the environment, which provides basic necessities such as food, water, air, and sunshine; materials for shelter, clothing and industry; and opportunities for recreation.

Health Practices and Coping Skills: An individual's health-promoting and health-compromising attitudes, beliefs and behaviors, and the ways in which people cope with stress.

Health Care Services: Access to and quality of health services to promote health and prevent and treat disease and other threats to health.

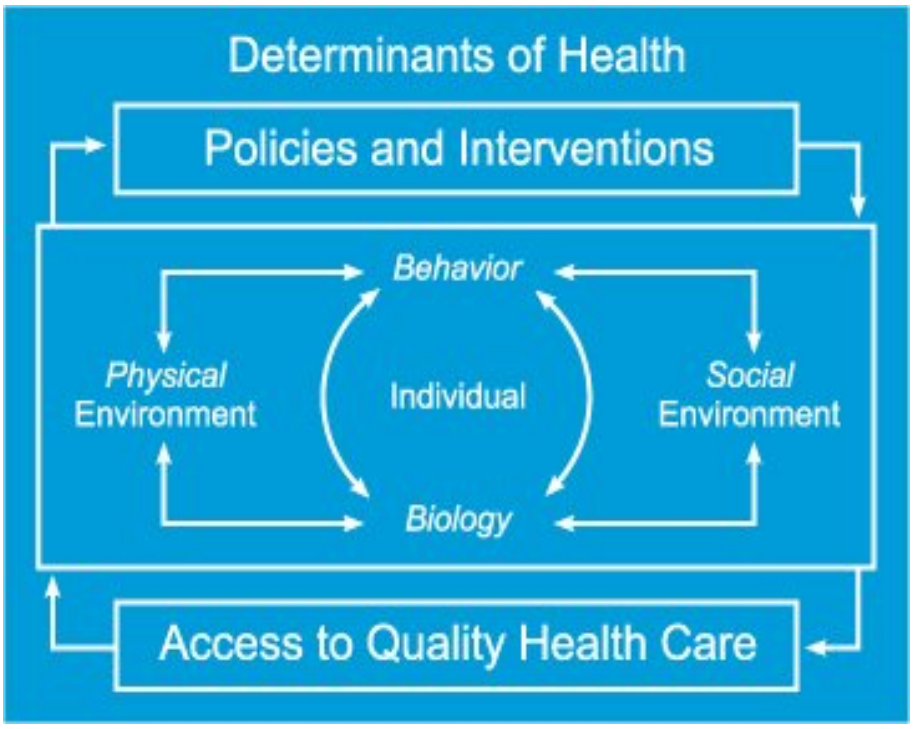
Biology: Genetic makeup, family history, and physical and mental health problems acquired during life (aging, diet, physical activity, smoking and drug use, stress, injury, and infections affect one's biology over the lifecycle).

Health literacy: the ability of an individual to seek out, comprehend, evaluate, and use health information and concepts to make informed choices, reduce health risks, and increase quality of life

Early child development (ECD): the cornerstone of human development; should be central to how we judge the successfulness of societies. Addressing ECD means creating conditions for children; prenatal to 8 years; to thrive equally in their physical, social/emotional, and language/cognitive development. Improved ECD not only means better health, but a more productive labor force, reduced criminal justice costs, and reductions in other strains on the social safety net.

IV. How Social Determinants influence Health

An Individual's *biology* and *behavior* combined with the individual's *social* and *physical environments* influence health. In addition, *policies and interventions* can improve health by targeting factors related to individuals and their environments, including *access to quality health care*. Equitable distribution of these social determinants contributes to **health equity**.



v. TENNESSEE AND HEALTH DISPARITIES

a. Demographics

Tennessee's population is comprised of 80% White/Caucasian, 16% African American, 2% Hispanic/Latino, 1% Asian/Pacific Islander, and <1% Native American

The white population's share of Tennessee's total population is projected to decline from 80% to 75% by year 2010, with a slight gain occurring in the black population, and significant gains in the Hispanic/Latino population and all other racial groups.

b. The State of Health Disparities in Tennessee:

This report will focus on six priority health areas: Tennessee's Infant Mortality Rate, Diabetes, Asthma, Obesity, HIV/AIDS and Cancer.

1. Infant mortality is defined as the number of deaths of infants (one year of age or younger) per 1000 live births.

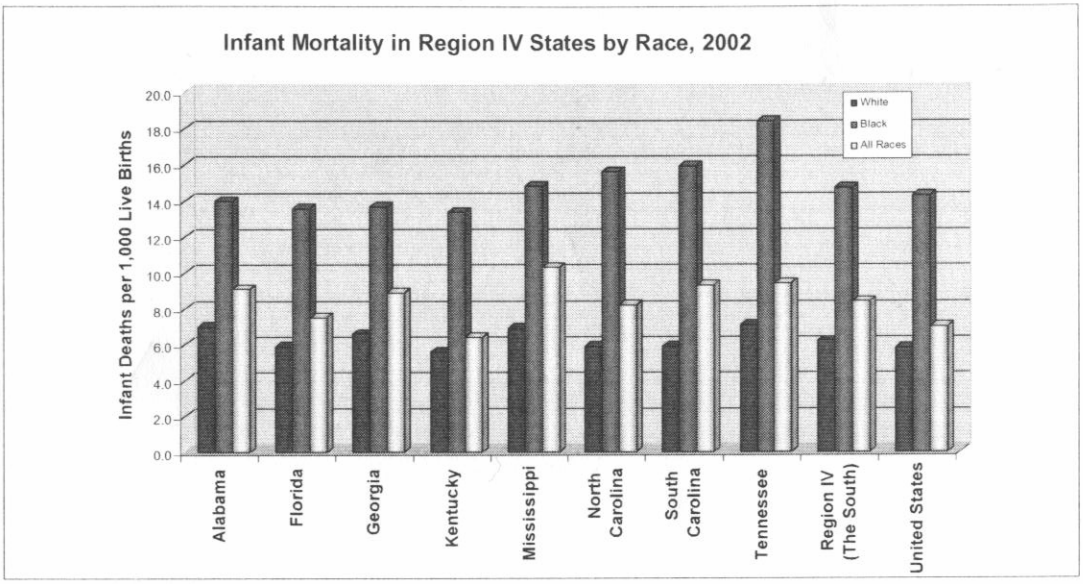
Infant mortality rate (IMR) is the number of newborns dying under a year of age divided by the number of live births during the year. As can be noted, the mortality rate for black infants is more than twice that of white infants.

The leading cause of infant mortality is congenital malformations, deformations and chromosomal abnormalities. Disorders related to short gestation and low birth weight is the second leading cause of death for all infants. Sudden infant death syndrome (SIDS) is the third leading cause of infant death. The fourth leading cause of death comes under the heading of newborn affected by maternal complications of pregnancy.

Infant Mortality Rate (Deaths per 1,000 Live Births) by Race/Ethnicity

	WHITE	AFRICAN AMER.	HISPANIC	TOTAL
UNITED STATES	5.7	13.6	5.6	6..9
TENNESSEE	7.0	16.3	6.5	9.0

Tennessee is ranked 45th worst state for infant mortality. The magnitude of the disparity in Tennessee is larger than the surrounding southern states. An African American baby being born in Tennessee has a greater chance of dying than if that baby were born in any other state in the South. Tennessee is the most dangerous state in the south for an infant to be born, in terms of infant mortality.



Six strategies that are essential to any plan aimed at further reducing the infant mortality rate:

- Address Disparities in Infant Mortality
- Provide Pre-Pregnancy Education and Counseling to All Women and Men
- Ensure Timely Prenatal Care for All Women
- Expand Access to Medical Care for Infants in the First Month of Life
- Expand Access to Well-Baby Care and Parenting Education
- Expand Programs for the Prevention of Child Abuse and Neglect

2. Diabetes (medically known as diabetes mellitus) is a group of serious, lifelong disease affecting 17 million Americans. All forms of the disease are caused by higher than normal levels of blood sugar, which is a result of the body not producing or properly using insulin. Insulin is a hormone that converts sugar, starches and other food into energy needed by the body.

Diabetes can lead to serious complications and premature death if blood sugar, blood pressure and cholesterol are not kept under good control. There are three different classifications of Diabetes: Type 1, Type 2, and Gestational Diabetes.

Number of Diabetes Deaths per 100,000 Population by Race/Ethnicity			
	WHITE	**AFRICAN AMERICAN**	**OTHER**
UNITED STATES	**22.5**	**47.0**	**20.5**
TENNESSEE	**26.3**	**57.0**	**NSD**

African Americans are 1.8 times more likely to have diabetes than whites of similar age. One in four, or 25%, of African Americans between the ages of 65 and 74 has diabetes. African Americans experience nearly three times as many deaths from diabetes as do Whites. African Americans experience higher complications than whites with diabetes. African Americans are almost 50% as likely to develop diabetic retinopathy, a type of eye disease which can lead to blindness. African Americans are 2.6 to 5.6 times as likely to suffer from kidney disease with more than 4,000 new cases of End Stage Renal

Disease (ESRD) each year. And African Americans with diabetes are 1.6 times more likely to suffer from lower-limb amputations.

*African American females died of **diabetes mellitus** at rates more than double that of white females. And regardless of race, females died of diabetes at higher rates than males.*

Tennessee	Annual age-adjusted Mortality Rates for Diabetes deaths per 100,000 women
White Female	**26.2**
African American Female	**54.0**

Diabetes during pregnancy increases the risk of birth defects and the rate of perinatal death. Compared with the state's white population, diabetes-complicated birth is greater in African Americans. Pregnancy complicated by diabetes is increasing faster among Hispanics/Latinos, American Indians, and Asian Americans than among whites. These groups are also at greater risk of receiving less than adequate prenatal care.

Racial and ethnic disparities in diabetes complications and diabetes-related deaths are made worse by a variety of factors, including poor access among non- white populations to diabetes medicines, supplies, and culturally and linguistically appropriate preventive care. Lack of culturally and linguistically appropriate diabetes education materials and support systems further impede effective diabetes management in these populations.

Specific Objectives
1. Conducts community outreach efforts that increase the public's awareness and knowledge about diabetes;
2. Educates diabetic patients about diabetes and its complications; and
3. Educate physicians on the current practice guidelines for treatment and management of diabetes.

3. Asthma is an inflammatory disorder of the airways, which causes attacks of wheezing, shortness of breath, chest tightness, and coughing. Asthma is caused by inflammation in the airways. When an asthma attack occurs, the muscles surrounding the airways become tight and the lining of the air passages swell. This reduces the amount of air that can pass by, and can lead to wheezing sounds.

Asthma symptoms can be triggered by breathing in allergy-causing substances (called allergens or triggers). Triggers include pet dander, dust mites, cockroach allergens, molds, or pollens. Asthma symptoms can also be triggered by respiratory infections, exercise, cold air, tobacco smoke and other pollutants, stress, food, or drug allergies. Aspirin and other non-steroidal anti-inflammatory medications (NSAIDS) provoke asthma in some patients.

Current prevalence of asthma in Tennessee is 8.5% in children and 8.4% in adults. That's roughly 286,000 asthma patients in the state.

• Among adults, asthma was more common among women than men. However, among children asthma prevalence rates were higher among boys.

- Asthma was more common among black children than white children. However, there were no racial differences in asthma prevalence among adults.

- Asthma prevalence increased with decreasing income and education

Hospitalizations, emergency department visits and deaths due to asthma are all indicative of severe and/or poorly managed disease and are costly both monetarily and in terms of personal suffering. However, such severe consequences are largely preventable with appropriate treatment and disease management. A recent report conducted by Asthma in America, revealed Tennessee is missing the mark in terms of asthma care. Some key findings are highlighted below.

Many Patients in Tennessee Are Uninformed

widespread misunderstanding about the causes and treatment of asthma. In Tennessee, 77% of asthma patients believe there is a “strong need” for patient education.

- Only 7% of those surveyed could name inflammation as the underlying cause of asthma symptoms.

More than half (54%) thought it was possible to treat only asthma attacks and symptoms, not their underlying cause.

Many Patients in Tennessee Treat the Symptoms of Asthma, Not the Disease Itself

The National Heart, Lung, and Blood Institute (NHLBI) guidelines recommend anti-inflammatory medication for patients with mild, moderate or severe persistent asthma. However, many patients in Tennessee appear to be treating only the symptoms of asthma and not the underlying inflammation:

- 62% of those surveyed who use a quick-relief inhaler use it three times a week or more -- indicating a need for long-term control medication, according to the NHLBI guidelines.
- About 1 in 11 people (9%) with persistent asthma take inhaled corticosteroids, the anti-inflammatory drugs the guidelines call “the most effective long-term control medication for asthma, and the preferred initial therapy for patients with persistent asthma” for patients five years of age and older.

Closing the Patient-Provider Communications Gap May Help

The national survey reveals real disparities between what doctors say and what patients say -- and suggests a communications gap exists between asthma patients and their healthcare providers.

- 70% of doctors surveyed say they use spirometry to measure patient airflow on an ongoing basis, but only 35% of patients report having a lung-function test in the past year.
- 92% of doctors surveyed say anti-inflammatory drugs are either “essential” or “very important” in the long-term management of persistent asthma, but only 19% of asthma patients report using anti-inflammatory medication in the past four weeks.
- 70% of doctors say they prepare a written action plan for their patients, but only 27% of patients say their doctor has developed one for them.

Objectives:

1. Education for a better partnership in care
2. Proper assessment and monitoring of the disease
3. Research and control of environmental factors

4. Obesity

A condition in which excess body fat has accumulated to such an extent that health may be negatively affected. It is commonly defined as a body mass index (BMI = weight divided by height squared) of 30 kg/m^2 or higher. Excessive caloric intake and a lack of physical activity in genetically susceptible individuals is thought to explain most cases of obesity, with purely genetic, medical, or psychiatric illness contributing to only a limited number of cases.

Obesity is a public health and policy problem because of its prevalence, costs, and health effects. Obesity increases the risk of many diseases and health conditions. These include–

- Hypertension (high blood pressure)
- Osteoarthritis (a degeneration of cartilage and its underlying bone within a joint)
- Dyslipidemia (for example, high total cholesterol or high levels of triglycerides)
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Gallbladder disease
- Sleep apnea and respiratory problems
- Some cancers (endometrial, breast, and colon)
- Obese individuals may also suffer from social stigmatization, discrimination, and lowered self-esteem.

Overweight and Obesity Rates for Adults by Race/Ethnicity, 2007	
Tennessee	**Percent**
Caucasian	**63.1%**
African American	**73.3%**
Hispanic	**NSD**
Asian / Pacific Islander	**NSD**
American Indian/Alaska Native	**NSD**
Other	**NSD**

Obesity is especially prevalent among women with lower incomes and is more common among African American and Hispanic women than among Caucasian women. Among African Americans, the proportion of women who are obese is 80 percent higher than the proportion of African American men who are obese. This gender difference also is seen among Hispanic women and men, but the percentage of Caucasian women and men who are obese is about the same. 43 percent of Tennessee children are either overweight or at risk for being overweight.

Public health efforts seek to understand and correct factors responsible for the increasing prevalence of obesity in the population. Solutions must involve all levels of influence (individual, interpersonal, organizational, community, and society) in order to support long-term, healthful lifestyle choices. Addressing obesity and other chronic diseases begins by changing everyday behaviors that relate to eating and physical activity. That means changing people's knowledge, attitudes, and beliefs. Interpersonal groups encourage more healthful behaviors, giving individuals the knowledge and support they need to make good nutrition and physical activity choices. Organizations (ex. - schools, places of employment, places of worship, sports teams, and volunteer groups) can help members make better choices about healthful eating and physical activity through changes to organization policies and environments, as well as, by providing health information. A community is like a large organization, able to make changes to policy and the environment to give residents the best possible access to healthful foods and places to be physically active (changes to zoning ordinances, improvements to parks and recreation facilities, and creating ways to distribute fruits and vegetables are only a few examples). Society, the all-encompassing category, must create a comprehensive strategy to address obesity and other chronic diseases. New nutrition and physical activity legislation, statewide school policies, media campaigns, and partnerships with business and industry are just some of the ways change takes shape on a large scale.

5. HIV/AIDS

AIDS is a chronic, life-threatening condition caused by the human immunodeficiency virus (HIV). By damaging your immune system, HIV interferes with your body's ability to fight off viruses, bacteria and fungi that cause disease. HIV makes you more susceptible to certain types of cancers and to infections your body would normally resist, such as pneumonia and meningitis. The virus and the infection itself are known as

HIV. "Acquired immunodeficiency syndrome (AIDS)" is the name given to the later stages of an HIV infection.

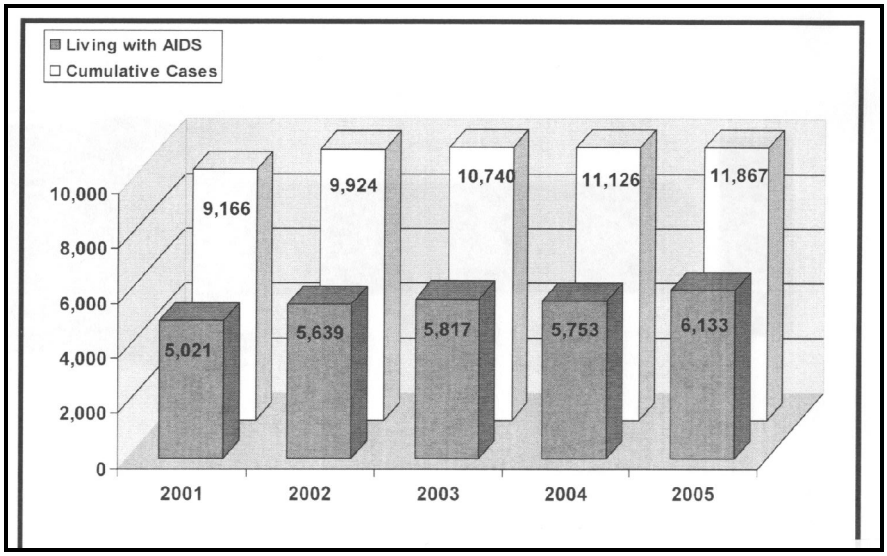
Causes
Normally, white blood cells and antibodies attack and destroy foreign organisms that enter your body. This response is coordinated by white blood cells known as CD4 lymphocytes. These lymphocytes are also the main targets of HIV, which attaches to the cells and then enters them. Once inside, the virus inserts its own genetic material into the lymphocytes and makes copies of itself.

When the new copies of the virus break out of the host cells and enter the bloodstream, they search for other cells to attack. In the meantime, the old host cells and some uninfected CD4 cells die from the effects of the virus. The cycle repeats itself again and again. In the process, billions of new HIV particles are produced every day. Eventually, the number of CD4 cells in the body decreases, leading to severe immune deficiency, which means your body can no longer effectively fight off viruses and bacteria that cause disease.

How HIV is transmitted
You can become infected with HIV in several ways, including: Sexual transmission, Transmission through infected blood, Transmission through needle sharing, Transmission through accidental needle sticks, transmission from mother to child, Other methods of transmission (in rare cases, the virus may be transmitted through organ or tissue transplants or un-sterilized dental or surgical equipment). You cannot become infected through ordinary contact — hugging, kissing, dancing or shaking hands — with someone who has HIV or AIDS.

Tennessee reported 11,867 AIDS cases to the Centers for Disease Control and Prevention, cumulatively from the beginning of the epidemic through December 2005. Tennessee ranked 18th highest among the 50 states in number of reported AIDS cases in 2005. Currently, there are persons living with HIV/AIDS in all 95 counties of the state.

The following data represent the total reported AIDS cases in Tennessee through year-end 2005:



Total Reported AIDS cases by Race/ Ethnicity, 2005

Race	Total Reported Aids cases	Percentage of total reported cases
African American (NH)	6,118	51%
Caucasian (NH)	5481	46%
Hispanic / Latino	226	2%
Asian / Pacific Islander	23	<1%
American Indian /Alaska Native	11	<1%
Unknown/ Multiple Race	41	<1%

Total Reported AIDS Cases by Counties, 2005

Shelby County	4449	Washington County	136
Davidson County	3097	Sumner County	125
Hamilton County	792	Montogomery County	117
Knox County	698	Sullivan County	118
Rutherford County	159	Bradley County	94
Madison County	143		

- The data confirms that HIV takes a disproportionate toll on African Americans and Hispanics/ Latinos.
- African American men have an HIV prevalence rate six times higher than that of Caucasian men
- African American women have an HIV prevalence rate 18 times higher than the rate for Caucasian Women
- Hispanic/Latino men have an HIV prevalence rate twice as high as the rate for Caucasian men.

- Hispanic/Latino woman have an HIV prevalence rate four times higher than Caucasian women.

Objectives for combating the spread of HIV/AIDS:

- Break the silence by raising awareness about HIV/AIDS among Minorities
- Encourage local governments and communities to expand and strengthen their responses to the HIV/AIDS epidemic among Minorities;
- Encourage individuals to be tested for HIV/AIDS;
- Increase access to HIV prevention and care services;
- Reduce barriers to HIV testing, prevention, and care by reducing HIV/AIDS stigma;
- Stimulate the development of a plan to address the disproportionate impact that HIV/AIDS is having on minority communities.

6. Cancer

Cancer (medical term: malignant neoplasm) is a class of diseases in which a group of cells display *uncontrolled growth* (division beyond the normal limits), *invasion* (intrusion on and destruction of adjacent tissues), and sometimes *metastasis* (spread to other locations in the body via lymph or blood). Nearly all cancers are caused by abnormalities in the genetic material of the transformed cells. These abnormalities may be due to the effects of carcinogens, such as tobacco smoke, radiation, chemicals, or infectious agents. Other cancer-promoting genetic abnormalities may be randomly acquired through errors in DNA replication, or are inherited, and thus present in all cells from birth.

Compared to other states, Tennessee has a cancer mortality rate that is one of the highest, ranked 46th for all cancers and races aggregated. The overall age-adjusted cancer mortality rate is 215.4 per 100,000 Tennessean compared to 197.8 per 100,000 U.S. residents. There are racial disparities in cancer mortality both nationwide and in Tennessee. For example, African-Americans in Tennessee exhibited a mortality rate of 274.4 per 100,000 from cancer, while the mortality rate among whites was 208.4 per 100,000 during the 1998-2002 period. Although there is a racial disparity in cancer mortality rates on the national level, the disparity is even greater in Tennessee.
Nationally, the mortality rate is 27 percent higher among African-Americans than whites, whereas in Tennessee it is 32 percent higher. Males of both races have a higher cancer mortality rate than females.

Specific cancers with the highest disparity
Specific cancers exhibit varying degrees of racial disparity. Colorectal cancer mortalities occurred at a rate of 33.6 per 100,000 African-Americans compared to 19.5 per 100,000 whites. This is contrasted to the national rates of 27.9/100,000 and 20/100,000 respectively. Breast cancer occurs at a 12 percent higher incidence among white women; however the mortality rate from breast cancer is 48 percent higher for African-American women. In other words, proportionally many more African-American women die from breast cancer than do white women, even though white women actually have a higher risk of developing the cancer. Lung cancer mortality rates are higher among males than females. African-American and white women in Tennessee have nearly the same mortality rate from lung cancer: 44.4 per 100,000 African-American women versus 44 per

100,000 white women. African-American males have higher lung cancer mortality rates: 121.9 per 100,000. This is higher than both the national average for African-American male lung cancer mortality (101.3 per 100,000 nationally) and the lung cancer rate for white males in Tennessee (102.3 per 100,000 white males). In turn, white males in Tennessee have a lung cancer mortality rate that is higher than the national average for white males (75.2 per 100,000). Tennessee ranks as nearly the worst state in lung cancer mortality rates - 48th in 2002.Prostate cancer is one of the greatest causes of mortality among African-American males and is more than two and a half times as frequent among white males: 72.6 prostate cancer deaths per 100,000 African-American males versus 28.6 deaths per 100,000 white males. African-Americans have much higher mortality rates among the cancers that are the biggest killers: colorectal, lung, prostate and breast. The cancers which are responsible for the majority of cancer deaths occur with startling disparity among minority and underserved communities.

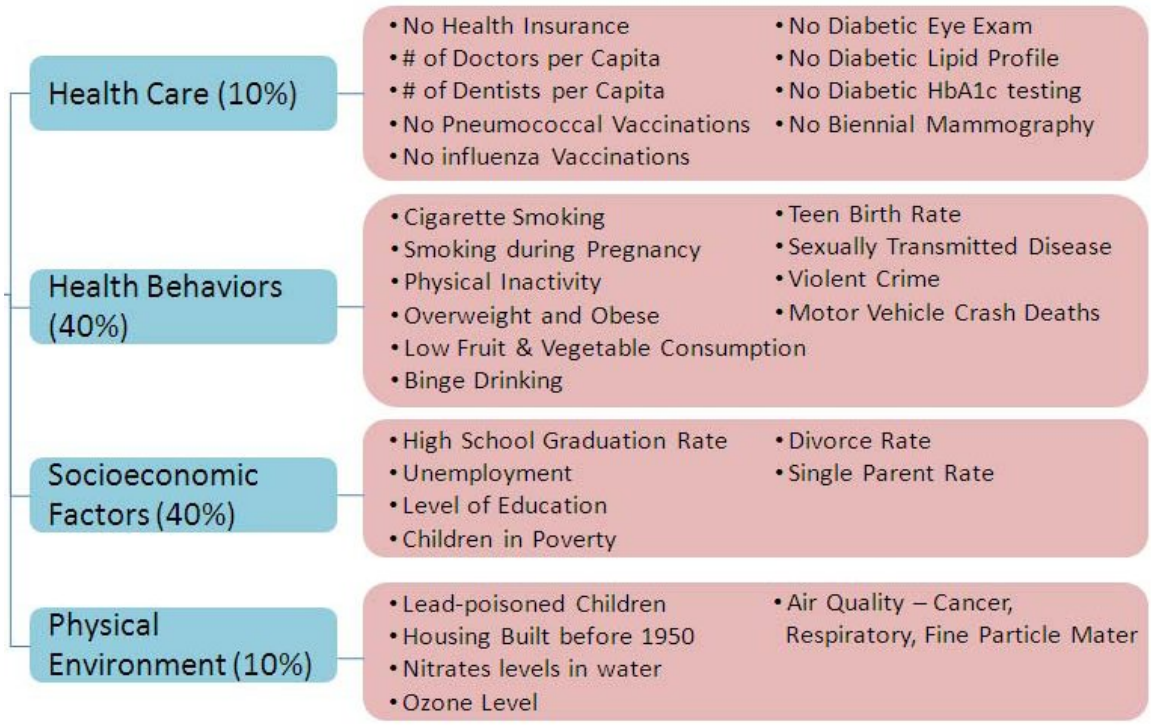
Objectives for combating Cancer:

- Eliminate barriers to screenings and follow up services
- Educate the public and providers about the need for screenings on a routine basis
- Increase accessibility and responsiveness of health systems to reach more at-risk populations
- Establish more and increase enrollment in clinical trials
- Increase timeliness of end-of-life care referrals for cancer patients

c. Measuring Health Disparities:

Assessing health equity requires measuring population-based data on health status, health care, and the social determinants of health that can be disaggregated by race or ethnic group, socioeconomic status, and gender, and how they change over time in relation to policies.

A report by the Tennessee Institute of Public Health, *"Tennessee County Health Rankings 2007"*, divides health determinant measures into four major components: health care, health behaviors, socioeconomic factors related to health, and the physical environment. Each of these four major components comprises multiple health determinants.



Tennessee Counties with the **BEST** health determinants outcomes:

Index Ranking	County
1	**Williamson**
2	**Rutherford**
3	**Wilson**
4	**Cheatham**
5	**Sumner**
6	**Knox**
7	**Hamilton**
8	**Moore**
9	**Stewart**
10	**Montgomery**

Tennessee Counties with the **WORST** health determinants outcomes:

Index Ranking	County
86	**Grundy**
87	**Hardin**
88	**Cocke**
89	**Campbell**
90	**Hardeman**
91	**Henderson**
92	**Hancock**
93	**Lake**
94	**Haywood**
95	**Lauderdale**

* For a complete listing of counties, please visit www.tn.gov/tniph

VI. **Economic Burden of Health Inequities**

The existence of health disparities is a complex economic burden that necessitates urgent, direct, and sustainable intervention.

Today, 47 million Americans, primarily Hispanics and African Americans, have no health insurance, while 36 million Americans live in poverty . Hospital emergency rooms have become the primary care facility for these groups. The Centers for Disease Control and Prevention, reports that chronic diseases account for more than 75 percent of the annual $1.4 trillion for medical care costs in the U.S.

The poverty gap between minorities and non-minorities is often greater in rural communities than in urban communities since economic resources can be more tightly constrained and limited. Also, many rural communities have limited access to health care because rural communities are often understaffed by health care professionals.

Delaying or not receiving treatment can lead to more serious illness and avoidable health problems. The uninsured are less likely to receive preventive care than those with insurance and more likely to be hospitalized for conditions that could have been avoided. For example, people with insurance are significantly more likely to have had recent mammograms, and other types of cancer screenings than the uninsured. Consequently, uninsured cancer patients are diagnosed later and die earlier than those with insurance. Researchers estimate that a reduction in mortality of 5% to 15% could be achieved if the uninsured were to gain continuous health coverage. The Institute of Medicine estimates that at least 18,000 Americans die prematurely each year because they lack health coverage. Charitable care and the safety net of community clinics and public hospitals do not fully substitute for health insurance. Lack of health coverage matters for millions of uninsured Americans, and places an indirect toll on society in terms of more disability, lower productivity, and increased burden on the health care system.

If the health disparities trend continues along the current path, without aggressive and transformational interventions, we will be faced with a resource-strained health care system where the majority of the population is in poor health, and a workforce that is not representative of the patient population. To preempt this prediction of health disparities, a paradigm shift is needed to keep pace with the changing demographic, and the evolving health disparities environment. New approaches that encompass preemptive, predictive, personalized, and participatory measures can help us to better understand and accelerate the elimination of health disparities.

VII. KEY RECOMMENDATIONS

Increased Awareness: create opportunities for dialogue and action among the general public and key stakeholders by promoting, developing, and investing in initiatives that work to eliminate health disparities.

Accountability and Ownership: Provide information to affected communities so that health disparities are known and knowledge is increased on how to access the best care and participate in treatment decisions.

Community Empowerment Promote and increase community level involvement by supporting leadership development and increasing the capacity within the community to develop solutions to issues that affect them. Additionally funding must be provided or re-oriented for community organizations that represent and serve the target population.

Create a culturally competent and diverse healthcare workforce. The area of workforce diversity must also consider preparing emerging health care professionals to work effectively as public health and health policy leaders.

Strengthen Assessment, evaluation, and research: commit to and budget for measuring disparities and monitoring of the elimination progress for all racial and ethnic groups.

Identify and Highlight Best Practices that are dedicated to improving the health of the disadvantaged and the disenfranchised.

Diversity of traditional and non-traditional constituents (i.e., foundations, civic planning organizations, local community leaders, physicians, community health centers, the faith community and elected officials-city, county, and state) to address the elimination of health disparities.

Develop Public Policies that have implications for improving and impacting health outcomes.

VIII. LOOKING FORWARD

Because racial and ethnic minority groups are expected to comprise an increasingly larger portion of Tennessee's overall population, the future health of Tennessee will be greatly influenced by our success in improving the health of these groups. Eliminating disparities will require a collaborative effort (encompassing policy makers, the public and private sectors, individuals, and communities) to raise awareness and increased knowledge of social determinants of health inequities and their influence on health, building skills and capacities to change a social determinant and altering social, economic, or environmental conditions through policies changes. Utilizing a combination of approaches increases the likelihood of reaching the desired goal - better health for all Tennesseans.

Short Term Goal:

- **Establish Opportunities for collaboration and Partnership Development:**
  The Health Equity Commission in conjunction with the Tennessee Department of Health and the Tennessee Black Caucus of State Legislators are planning the 13th Annual Minority Health Summit. The goals of the Summit are to increase knowledge of the social determinants of health, present research findings and best practices that are successfully addressing health disparities, develop integrative models for preventing disease and promoting health equity, create dialogue among policy makers, community leaders, health service providers and other stakeholders to examine and shape policy recommendations.

Long term goal:

- **Develop a state wide database of health disparity programs and initiatives** (including outcomes/results) to facilitate better coordination and collaboration of health disparity efforts in the state.
- **Establish a system of accountability for outcomes**
  Develop Evaluation models that assess both short and long term individual and systemic changes as a result of an initiative.
- **Invest more funding in prevention and education** to influence behavior and lifestyle changes. Prevention initiatives or interventions need to be culturally appropriate, target individuals early in life and address institutional systems.
- **Implement models of community development**
  Identify and train community leaders who play a key role in disseminating prevention messages and providing care, particularly to rural and underserved communities. Enhance capacity and participation in planning and implementing community-based health initiatives.

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